(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
	EMERITUS AT VININGS PLACE **4375 BEECH HAVEN TRAIL SE** **SMYRNA, GA 30080**	**02/09/2007**

A 000 Opening Comments

THIS REPORT WAS REVISED ON 2/26/07 BASED ON SUPERVISORY REVIEW.

>>>>The purpose of this visit was to conduct an annual inspection and investigate self-reported incident #GA00038702.

On-site visits were made to the facility on November 15, 16, 17, 20, 21, 22, 26, 29, 2006, January 18 and 31, 2007 and February 1, 2007. The investigation was completed on February 9, 2007.

A 005 Administration.
SS=D

(4) Each home shall have a written and regularly rehearsed disaster preparedness plan, approved by the Department, in compliance with O.C.G.A. 31-7-3(c).

Evacuation plan drills shall be held by each home at least semiannually.
****>>>>Based on record reviews and staff interviews, the facility did not have a disaster preparedness plan approved by the Department, in compliance with O.C.G.A. 31-7-3 (c). This resulted in no actual harm with the potential for more than minimal harm. Findings include:

The facility's current disaster plan did not address:
who has primary responsibility for rehearsals and implementation of the plan;
forwarding any changes to the disaster plan to the Department for approval;
loss of air conditioning or heat; and
the provider's commitment to notify the Department of any changes made to the disaster plan.

The plan did not stipulate that when other emergency situations dictate implementation of the plan, a written incident report and a critique of performance under that plan would be done.

The plan did not show approval by the person legally responsible for the facility's operation.

In an interview on November 29, 2006 at 11:20 a.m., staff A, the regional director of operations, stated the plan did not include the loss of heat or air conditioning.

A1501 Services.
SS=J

(1) Each personal care home shall provide room, meals and personal services to the residents of the home which are commensurate with the needs of the individual residents.

The personal services shall include 24-hour responsibility for the well-being of the residents.

Each home shall provide individual residents protective care and watchful oversight including but not necessarily limited to, a daily awareness by the management of resident's functioning, his or her whereabouts, the making and reminding a resident of medical appointments, the ability and readiness to intervene if a crisis arises for a resident, supervision in areas of nutrition, medication and actual provision of supportive medical services.

Personal services shall be provided by the administrator or on-site manager or by appropriately qualified staff designated by the administrator or on-site manager.
****>>>>Based on resident and staff interviews and record reviews, the facility failed to provide protective care and watchful oversight in the area of medication supervision to eight (8) of thirty-seven (37) residents sampled (#1, 5 10, 11, 17, 23, 33 and 45). This resulted in an imminent and serious threat to resident health and safety. Findings include:

A review of the 2006 Medication Assistance Records (MAR) on November 16, 2006, for resident #1 showed that Medication K, to be taken twice a day, was not available February 21 through 27 and March 18 through 22, 2006. In an incident report dated March 21, 2006, resident #1 hit an unidentified staff person on face and glasses.

A review of the 2006 MAR on November 16, 2006, for resident #5 showed that Medication L, to be taken twice a day, was not available March 25 through 28, 2006.

A review of the 2006 MAR on November 16, 2006, for resident #10 showed that Medication Q, to be taken in the morning, was not available February 25 and 26, March 18, 21 and 25, 2006. Medication Q, to be taken in the evening, was not available February 9, March 18 and 21, 2006. Medication A, to be taken daily, was not available February 25 and 26, 2006.

A review of the 2006 MAR on November 21, 2006, for resident #11 showed that Medication S, to be taken at bedtime, was not available March 25 through 29; Medication P, to be taken at 5:00 p.m., was not available March 27 and 28 and Medication I, to be taken at 9:00 a.m., was not available March 29.

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A record review on November 20, 2006, showed resident #17 had a physician's order for Medication F, one mg every eight hours as needed and Medication O, one to two tablets every four to six hours as needed. Facility interdisciplinary progress notes (progress notes) dated November 6, 2006, stated resident #17's daughter asked that Medication O and Medication F not be given to the resident. Staff I, the former nurse, documented the following in the facility progress notes, "inform dtr that the we would not give these meds to resident, phoned staff and asked caregiver on duty to wrap meds up and put note stating to hold meds (Medication F and O) per family request".

In an interview November 20, 2006, staff D stated that resident #17's daughter does not want the resident to have Medication O so staff does not give it to her. There was no documentation that the medications were discontinued by the resident's physician.

In an interview on November 22, 2006, staff H, the evening shift supervisor, stated that if a family does not provide the medication and/or refills, the facility can get the medication from a pharmacy until the resident's family can provide the medication.

A review of the December 2006 MAR for resident #23 was conducted on February 1, 2007 and showed that the following medications were not available: Medication A, to be taken at bedtime, December 14 through 17; Medication Q, at 5:00 p.m. on December 18 and 9:00 a.m. on December 28; Medication E, at 9:00 a.m. on December 28 and Medication N, daily on December 9.

A review of the January 2007 MAR for resident #23 was conducted on February 1, 2007, and showed that the following medications were not available on January 5: Medications M, R, C, N and G.

A review of the January 2007 MAR for resident #33 was conducted on February 1, 2007, and showed that Medication H was not available January 9, 2007.

In an interview on January 31, 2007, staff C stated that resident #45 had been out of Medication J for a few weeks. Resident #45 was taking this medication for knee pain.

A review of the MAR for resident #45 showed that Medication J was not available from January 8 through 17, 2007, when the medication was placed on "hold" due to unavailability.

In an interview on January 31, 2007, staff B, the administrator stated that she was not aware of any residents being out of medications, but when this happens, the facility will purchase the medications.

The facility policy titled Drug Discrepancies and Medication Errors was reviewed on November 17, 2006, and stated that failure to be sure medications are ordered and a missed dose of medication are considered to be medication errors and require an incident report to be completed. There were no incident reports written when medications were not available for these residents.

The facility's Medication Assistance policy reviewed on November 17, 2006, stated that the Executive Director or Designee shall assure that residents shall have timely refills and do not run out of medications.

The facility failed to follow their own policy to ensure that all residents receive physician ordered medications.

A1601 Staffing.
SS=J

(1) The home shall have as many employees on duty at all times as may be needed to properly safeguard the health, safety and welfare of the residents, as required by these regulations. As a minimum the following shall be observed:

(a) At least one administrator, on-site manager, or a responsible staff person shall be on the premises twenty-four (24) hours per day.

Residents shall not be left unsupervised.

A minimum on-site staff to resident ratio shall be one (1) staff person per fifteen (15) residents during waking hours; and one staff person per twenty-five (25) residents during non-waking hours;

****>>>>Based on record reviews, observation and staff interviews, the facility failed to have as many staff on duty as needed to properly safeguard the safety and welfare of the residents. This resulted in an imminent and serious threat to resident health and safety. Findings include:

A review of the 2006 incident reports on November 22, 2006, showed the following incidents for resident #7:
June 8, found on floor with a skin tear; June 14, fell without injury; June 17, slid down with skin tear and swelling on forehead; June 21, found on floor with a bruise and June 26, found on floor with skin tear on forehead that required an emergency room visit.

On December 27, 2006, the hospice admission notes dated June 27, 2006 were reviewed and stated that resident #7's eyes were black and blue from the fall.

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A review of the 2006 incident reports on November 21, 2006, showed the following incidents for resident #11:
March 28, 7:30 a.m., found on floor; July 28, fell in dining room with cut to left hand requiring sutures; Oct 8, found on floor and November 19, fell.

A review of an incident report on January 18, 2007, showed that resident #11 was found on floor on December 1, 2006, and sent to the hospital.

A review of an incident report on January 31, 2007, showed that resident #11 was found sitting on the floor on January 19, 2007.

A review of the 2006 incident reports on November 21, 2006, showed the following incidents for resident #14:
June 27, found on floor with bruises to both knees; July 4, fell in living area; August 7, found in floor with bruises to both knees; November 2, found in floor and November 13, found in floor with cut/skin tear to right hand.

A review of an incident report on January 18, 2007, showed that resident #14 was found on floor on December 28, 2006.

A review of an incident report on January 31, 2007, showed resident #14 was found on the floor in the day room on January 30, 2007.

A review of incident reports and progress notes for resident #24 on November 21, 2006, showed the following incidents in 2006:
May 5, resident found on the floor with pain in the left groin area; June 16, resident exhibiting agitated behavior, swinging hands and kicking items with a bruise noted to the resident's little finger; July 19, staff heard resident yelling and found resident on the floor with a skin tear to the upper arm; July 27, resident found on the floor with skin tear and swelling to the arms; August 23, resident fell while attempting to sit in a wheelchair and sustained red areas to both shins; September 27, staff observed resident #24 on ground with abrasion to forehead and bridge of nose and right little finger was deformed and bruised, sent to hospital; October 6, resident very agitated with skin tears to left forearm; October 8, resident found on the floor no injury noted; October 13, resident tried to bite a staff member and bit a chair, breaking the skin of lip; October 23, resident #24 was agitated and up and down all night, staff later found a hematoma and swelling on resident's right forearm; October 24, resident very agitated and yelling, the hematoma was bleeding into tissue and resident sent to the emergency room and diagnosed with a wrist sprain; November 4, resident was found on the floor with a bruise to the right buttock and November 19, resident #24 fell and sustained a fractured femur. The facility fall risk screening form for resident #24 was dated October 8, 2006 and stated resident was at high risk for falls.

A review of incident reports and progress notes for Resident #26 on November 21, 2006 showed the following incidents in 2006:
February 5, found on floor with a bruise to the shoulder; March 11, found on floor without injury; March 25, found on floor with a cut to the forehead that required an emergency room visit; April 2, found on floor without injury; April 20, found on floor without injury; April 24, pushed self out of wheelchair and re-injured forehead; May 10, found on floor; May 30, found on floor without injury; June 6, slid out of wheelchair without injury; June 27, found on floor without injury; June 30, found on floor with a bruise to the forehead and right leg; July 1, found on floor without injury; July 11, found on floor without injury; July 17, fell with a cut on nose and on July 21, found on floor with injury to right hand.

A review of the progress notes showed resident #26's gait very unsteady on July 13 and 14 and on July 13, the bruise on right flank area is fading. A review of the Resident Care Record for July 2006 showed resident #26 is independently mobile.

A review of incident reports and progress notes for resident #33 on November 21, 2006, showed the following incidents in 2006:
February 23, stumble/fall with redness on forehead; March 24, resident #33 pushed another resident that resulted in an injury to the other resident; May 8, found on floor with a gash on the head that required staples; August 25, found on floor with a red area on the hip; September 9, found on floor without injuries; October 2, fell without injuries; November 11, fell with a cut to the hand and swelling on top of the head and on November 27, found on floor without injury. A review of the fall risk assessment forms dated May 8 and August 28, 2006, showed resident #33 was at high risk for falls.

The following residents were "found outside":

A review of incident reports and progress notes on November 22, 2006, showed resident #6 was found lying on ground with no injury on December 7, 2006. On June 28, 2006, resident #6 was found outside on the ground and on July 3, 2006, resident received bruising to the right eye and surrounding area when found outside on ground with wheelchair tipped over. The resident was sent to the hospital twice on July 3 and again on July 6, 2006, for seizures and vomiting. A review of the May, June and July 2006 Resident Care Record for resident #6 showed documentation under Special Needs to "monitor closely will walk outside."

A review of an incident report on November 22, 2006, showed that resident #11 was found outside lying on grass with no injury on August 20, 2006.

A review of incident reports and progress notes on November 22, 2006, showed that resident #12 was observed on the ground outside in the courtyard with abrasion to the right side of face on April 30, 2006. Physician not notified until May 8, 2006. On July 14, 2006, staff found resident outside on the ground without injury.

A review of an incident report and progress notes on November 22, 2006, showed that resident #14 was found outside in the courtyard on

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March 22, 2006. The resident complained of pain and was taken to hospital with possible arm fracture.

A review of an incident report on January 31, 2007, showed that resident #14 was found outside, lying on right side, on January 19, 2007.

A review of incident reports and progress notes on November 22, 2006, showed that resident #18 wandered all night into and out of building on June 26, 2006. On June 27, 2006, staff escorted resident into the building on several occasions. On June 28, 2006, the resident continued to wander in the courtyard. On June 29, 2006, resident was wandering in and out of the facility and trying to leave building. On July 5, 2006, staff contacted the physician because of resident's continued attempts to leave the facility. On July 6 and 10, 2006, the resident continued to wander outside.

A review of an incident report on November 22, 2006, showed that resident #21 was found outside on grass and complained of knee pain on July 18, 2006.

A review of progress notes on November 22, 2006, showed that resident #34 was found outside with a hematoma to the forehead on April 3, 2006. Resident was sent to emergency room and returned with a diagnosis of right knee sprain.

A review of an incident report on January 31, 2007, showed that resident #14 was found outside lying on the ground on January 19, 2007.

In a confidential interview on December 5, 2006, AA stated that resident #6, 11, 12 and 14 could push the door open to go outside, but could not remember how to open the door to get back into the building.

In an interview on November 17, 2006, staff B, the administrator, stated that staff make rounds every two hours. When a resident is found missing, staff check the courtyard. The courtyard is accessible to residents throughout the day. There is no system in place for routinely monitoring residents who enter the courtyard and assuring their safe return into the building.

There is no staff to provide oversight when residents are in the courtyard or to assure their safe return into the facility.

In an interview on November 22, 2006, staff K, the activity director, stated that activities are offered from 9:30 a.m. to 12:00 p.m., Monday through Friday. Residents can come and go as they please. Staff K stated that she watches the residents while they are in the activity area and when they leave the activity area, everyone else is responsible. In an interview on November 20, 2006, staff E stated that some residents do not stay in activities. The person doing activities is responsible for those residents so the staff can do their cleaning assignments. In an interview on November 22, 2006, staff H, the second shift supervisor, stated that the other staff are responsible for checking the residents in all areas. In an interview on November 20, 2006, staff F stated that staff do their cleaning assignments while the residents are in activities.

Cleaning duties are assigned to each caregiver on each shift. In an interview on November 20, 2006, staff E stated that there is not enough time to do everything and not enough help.

In an interview on November 20, 2006, staff F stated that it is hard to get everything done and sometimes has to let the housekeeping go in order to take care of the residents.

In an interview on November 22, 2006, staff H, the evening supervisor, stated that an
activity is offered at 6:00 p.m. by utilizing one of the four caregivers scheduled to work the evening shift.

In an interview on November 22, 2006, staff K, the activity director, stated that activities are scheduled seven days a week. Staff K stated that if an activity assistant is not working on the weekends, one of the four caregivers does the activities.

In an interview at 11:00 a.m. on November 21, 2006, staff E stated that there was no staff to provide relief for lunch breaks. When staff leave their halls for a lunch break, they tell a staff person on another hall that they are on break.

During a tour at 1:00 p.m. on November 21, 2006, no staff were observed on the Bungalow hall. In an interview on November 21, 2006, staff D stated that he had to leave the hall to obtain supplies. Staff D stated that there is no one to provide relief for lunch breaks.

During a tour on November 22, 2006, at 8:40 a.m., eight residents were observed in the dining room on the Bungalow hall and no staff were observed on the hall. Staff D was working alone on the hall and stated he had to leave the hall to get supplies. At 9:40 a.m., staff D was observed in the administrator's office (staff B). At 10:45 a.m., three residents were observed alone on the Bungalow hall. At 11:40 a.m., staff D was observed on another hall.

In an interview on November 22, 2006 at 11:45 a.m., staff H stated that there are never enough staff, residents can wander while staff are giving showers.

During a tour of the facility, the staff on the Roycroft hall were going to lunch and staff O stated that they notified the staff on the other hall so they could come over and check on the residents.

During an interview on January 31, 2007, staff B, the administrator stated that supplies are now brought to staff so they do not have to leave their halls to obtain supplies.

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Cross refer to Rule 290-5-35-.18(1)(h) Residents' Rights A2108.

A1702 Personnel.
SS=D

(2) The administrator or on-site manager shall be responsible for ensuring that:
Any person working in the facility as an employee, under contract or otherwise, receives work-related training acceptable to the Department within the first sixty days of employment. Such training shall at a minimum include the following:

(a) Current certification in emergency first aid except where the staff person is a currently licensed health care professional;

(b) Current certification in cardiopulmonary resuscitation;

(c) Emergency evacuation procedures;

(d) Medical and social needs and characteristics of the resident population;

(e) Residents' rights; and

(f) Receiving a copy of the Long-Term Care Abuse Reporting Act O.C.G.A. Section 31-8-50 et.seq.

****>>>>Based on record review and staff interview, the facility did not ensure that two (2) of twelve (12) sampled staff (J, P) had received the necessary work related training required by the Department within the first sixty (60) days of employment. This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of facility payment records for staff J on November 16, 2006, showed that staff J has worked at the facility since March 2006. There was no documentation of staff J having training in emergency first aid; cardiopulmonary resuscitation (CPR); emergency evacuation procedures; the medical and social needs and characteristics of the resident population and residents' rights; and the Long-Term Care Resident Abuse Reporting Act.

In an interview on November 22, 2006, staff B, the administrator, stated that staff J will begin working as an employee on November 27, 2006 and all training will be completed.

A review of the file of staff P on January 31, 2007, showed he was hired on December 1, 2006. There was no documentation of staff P having training in: emergency evacuation procedures; the medical and social needs and characteristics of the resident population; residents' rights; and receiving a copy of the Long-Term Care Resident Abuse Reporting Act.

In an interview on February 1, 2007 at 7:15 a.m., staff P stated that he was still in orientation and had not received training on the above topics.

A1706 Personnel.
SS=D

(6) The administrator, on-site manager, and each employee shall have received a tuberculosis screening and a physical examination by a licensed physician within twelve months prior to employment (or initial application for permit or granting a permit to the home) sufficiently comprehensive to assure that the employee is free of diseases communicable within the scope of employment and physically qualified to work.

Follow-up examinations shall be conducted by a licensed physician of each administrator or staff person to determine readiness to return to work following a significant illness or injury.

Copies of information regarding staff member health shall be kept in the staff person's personnel folder.
****>>>>Based on record review and staff interview, the facility failed to ensure that one (1) of nine (9) sampled staff received a physical examination by a licensed physician and had a tuberculosis screening within twelve months prior to employment (J). This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of facility payroll records for staff J on November 16, 2006, showed that staff J has worked at the facility since March 2006. There was no documentation that staff J had a physical examination from a licensed physician or a screening for tuberculosis.

In an interview on November 22, 2006, staff B, the administrator, stated that staff J has been working by contract but will begin working as an employee on November 27, 2006.

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A1708 Personnel.
SS=D

(8) All persons employed by the home must obtain a satisfactory criminal records check determination from the Department.
****>>>>Based on record review and staff interview, the facility did not ensure that one (1) of nine (9) sampled staff (J) had obtained a satisfactory criminal record check. This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of facility payroll records for staff J on November 16, 2006, showed that staff J has worked at the facility since March 2006. There was no documentation that staff J had a criminal record check determination.

In an interview on November 22, 2006, staff B, the administrator, stated that staff J has been working by contract but will begin working as an employee on November 27, 2006, and a criminal record check would be done.

A1710 Personnel.
SS=D

(10) A personnel file shall be maintained in the home for each employee. These files shall be available for inspection by the appropriate enforcement authorities but shall otherwise be maintained to protect the confidentiality of the information contained in them, and shall include the following:

(a) Evidence of a satisfactory fingerprint record check determination or a satisfactory criminal records check determination.

(b) Physician's report of physical examination;

(c) For administrators, on-site managers and staff persons, evidence of first aid and cardiopulmonary resuscitation training and recertification as required; and

(d) Employment history, including previous places of work and employers.

****>>>>Based on record review and staff interview, the facility failed to have an employee file for one (1) of nine (9) sampled staff (J). This resulted in no actual harm with the potential for more than minimal harm. Findings include:

In a review of staff files on November 17, 2006, staff J did not have a file. A review of facility payroll records for staff J showed that staff J has worked at the facility since March 2006.

In an interview on November 22, 2006, staff K, the activity director, stated that staff J mostly works weekends, but has worked up to three days a week while staff K was out of town.

In an interview on November 22, 2006, staff B, the administrator, stated that staff J has been working by contract but will begin working as an employee on November 27, 2006, and will complete the required training.

A1805 Admission.
SS=D

(e) Medical, nursing, health or supportive services required on a periodic basis, for short-term illness, shall not be provided as services of the home.

When such services are required, they shall be purchased by the resident or resident's representative or legal surrogate, if any, from appropriately licensed providers managed independently of the home.

The home may assist in arrangement for such services, but not provision of those services.

****>>>>Based on staff interview and record review, the facility provided nursing services to one (1) of twenty-five (25) residents (#18) and staff were administering medications to eleven (11) of thirty-five (35) residents (5, 12, 13, 14, 15, 16, 17, 24, 27, 30, 32). This resulted in no actual harm with the potential for more than minimal harm. Findings include:

On February 1, 2007, a review of the file of resident #18 showed that on December 26, 2006, the great toe of resident #18 was swollen with red drainage. On December 28, 2006, the toenail was removed from the right great toe. The MAR for resident #18 showed that staff were providing daily and, as needed, dressing changes for excessive drainage until the wound was healed.

In an interview on January 31, 2007, staff B, the administrator, stated that the facility does dressing changes.

Cross refer to Rule 290-5-35-.15(2) Admission A1806.

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A1806 Admission.
SS=J

(2) No home shall admit or retain a resident who needs care beyond which the facility is permitted to provide.

Applicants requiring continuous medical or nursing services shall not be admitted or retained.
****>>>>Based on observation, record reviews and staff interviews, the facility retained fifteen (15) of thirty-five (35) residents sampled (3, 5, 9, 12, 13, 14, 15, 16, 17, 19, 22, 24, 27, 30, 32) who needed care beyond that which the facility is permitted to provide. This resulted in an imminent and serious threat to resident health and safety. Findings include:

The facility retained fifteen residents who require the nursing service of administration of medications:

The March 2006 Resident Care Record for resident #5 was reviewed on November 22, 2006. The record stated to give medications in applesauce.

A review of medical records on November 22, 2006, showed that physician's order for admission for resident #5, stated that medications are to be administered by a licensed professional.

On November 22, 2006 at 8:25 a.m., resident #12 was observed taking morning medications crushed by staff C and placed in peanut butter that were then spread on a biscuit. Staff C stated that she poured the liquid medications in the resident's juice.

In an interview on November 20, 2006, staff F stated the medications are crushed and put in food for resident #12.

In an interview on January 18, 2007, staff M stated that she crushes the medications for resident #12 and puts them in pudding and feeds them to the resident.

In an interview on February 1, 2007, staff O stated that the medications for resident #12 were crushed and put into food and fed to the resident. Liquid medications were put in the resident's juice.

In an interview on November 20, 2006, staff E stated that resident #13 spits the medications out and throws the water at the caregiver. Staff E stated that all the medications are crushed and given in yogurt. Physician's order dated June 22, 2006, state to crush medications if needed, but cannot crush Medication B.

In an interview on November 20, 2006, staff F stated the medications are crushed and put in food for resident #13.

In an interview on January 18, 2007, staff C stated that she crushes the medications, puts them in applesauce and tells resident #13 that it is a treat.

On January 31, 2007 at 11:55 a.m., staff C was observed crushing Seroquel and administering the medication to resident #13 in applesauce.

On November 22, 2006 at 9:13 a.m., resident #14 was observed taking morning medications that staff D had put on a spoon and then placed the spoon in the resident's mouth to get the resident to take the medications.

In an interview on November 20, 2006, staff F stated the medications are crushed and put in food for resident #14.

In an interview at 8:30 a.m. on January 31, 2007, staff N stated that the medications for resident #14 were crushed and put into applesauce.

At 8:40 a.m. on January 31, 2007, staff N was observed crushing the morning medications and administering the medications to resident #14 in applesauce.

In an interview on November 20, 2006, staff F stated the medications are crushed and put in food for resident #15.

The facility was granted a waiver with conditions for Rule 290-5-35-.15(2) for resident #16 on January 19, 2006. The facility is not meeting the following conditions of the waiver:
Condition #1 The resident does not experience a significant change in their physical or medical condition which would make continued placement in this home inappropriate;
Condition #2 The home maintains responsibility for meeting the resident's need for continuing care provided within the scope of custodial care that the personal care home is permitted to deliver. The home is not licensed to deliver nursing services but will provide watchful oversight to ensure that the needs of these residents, as well as all other residents, are met.

Resident #16's condition changed to require administration of medications. On November 2, 2006 at 9:50 a.m., resident #16 was observed taking morning medications that staff D crushes and puts in the liquid medication that is then put in the resident's mouth.

A review of medical records on November 22, 2006, showed that physician's order for admission for resident #17 stated that medications are

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to be administered by a licensed professional.

A review of medical records on November 22, 2006, showed that physician's order for admission for resident #24 stated that medications are to be administered by a licensed professional.

On November 22, 2006 at 8:45 a.m., resident #27 was observed taking morning medications. Staff D stated if the resident did not take the medications, the medications were crushed and put in yogurt and fed to the resident.

On November 22, 2006, a review of facility progress notes dated August 30, 2006, showed that a physician's order was obtained by staff I to crush the medications of resident #27 because the resident refused to to take medications.

In an interview on January 31, 2007, staff N stated that the medications for resident #27 were crushed and put into applesauce or yogurt. Staff N stated that resident #27 gets mean and does not want to take the medication.

On January 31, 2007, staff N was observed crushing the morning medications, including Aspir-Low, for resident #27. The MAR had a statement, "do not crush" Aspir-Low. The medications were put in applesauce. Resident #27 asked staff N, "what is that?", staff N told the resident it was applesauce.

On November 22, 2006 at 11:00 a.m., staff C stated that if resident #30 does not take the medications, they are then crushed and put in the resident's food.

A review of medical records on November 22, 2006, showed that physician's order for admission for resident #32 stated that medications are to be administered by a licensed professional.

In an interview on November 22, 2006, staff B, the administrator, stated that she was aware that residents' medications were being crushed and put in food so the residents would not spit them out. In an interview on January 31, 2007, staff B, the administrator, stated that residents self-administer their medications by feeding themselves the food that has their medications in it.

The facility policy stated residents requiring continuous medical or nursing services should not be admitted or retained.

A review of the file of resident #3 was conducted on November 20, 2006. The physician's report dated March 24, 2006, stated that resident #3 required 24-hour nursing supervision.

In an interview on November 20, 2006, staff B, the administrator, stated that she was not aware of the statement on the physician's report.

The facility retained residents who needed more care than the facility is permitted to provide.

A review of the file of resident #5 on November 22, 2006, showed the resident fell on June 6, 2006, and sustained a fractured hip. The resident had hip surgery and returned to the facility on June 9, 2006, bed bound. On June 13, 2006, resident #5 was seen in the emergency room and returned to the facility on June 15, 2006, with hospice services. Resident #5 expired at the facility June 16, 2006.

Hospital records reviewed on January 11, 2007, stated that resident #5 was returned to the facility after hip surgery because the resident was a poor rehabilitation candidate and was unable to follow commands because of dementia.

A review of the file of resident #9 on November 26, 2006, showed the resident went to the hospital on August 4, 2006, with atrial fibrillation, pneumonia, urinary tract infection and sepsis. The resident was not responding to antibiotic therapy and was discharged to the facility with palliative treatment and hospice services.

In an interview on November 20, 2006, staff F stated that resident #15 cannot move her wheelchair very well and staff help her. Staff D stated that resident #15 will self-propel her wheelchair only when she wants to.

In an interview on January 18, 2007, staff F stated that resident #15 can only move the wheelchair a little bit.

In an interview on January 31, 2007, staff N stated that resident #15 is stubborn sometimes and will not move her wheelchair.

On November 15, 2006, resident #19 was observed in a wheelchair. In interviews on November 20, 2006, staff D, F and G stated that resident #19 cannot self-propel a wheelchair.

Facility progress notes state that resident #22 was in a wheelchair when out of bed. In an interview on November 22, 2006, staff H, the second shift supervisor, stated that resident #22 is not able to move the wheelchair.

In an interview on January 31, 2007, staff B, the administrator, stated that all residents can ambulate or move their wheelchairs, but they have dementia and cannot always understand commands to move.

A1901 Admission Agreement.

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SS=D

(1) A written admission agreement shall be entered into between the governing body and the resident. Such agreement shall contain the following:

(a) A current statement of all fees and daily, weekly or monthly charges; any other services which are available on an additional fee basis, for which the resident must sign a request acknowledging the additional cost and the services provided in the home for that charge;

(b) A statement that residents and their representatives or legal surrogates shall be informed, in writing, at least sixty (60) days prior to changes in charges or services;

(c) The resident's authorization and consent to release medical information to the home as needed:

(d) Provisions for the administrator or on-site manager's continuous assessment of the resident's needs, referral for appropriate services as may be required if the resident's condition changes and referral for transfer or discharge if required due to a change in the resident's condition;

(e) Provision for transportation of residents for shopping, recreation, rehabilitation and medical services, which shall be available either as a basic service or on a reimbursement basis, and providing that transportation for emergency use shall be available at all times;

(f) A statement of the home's refund policy when a resident is transferred or discharged;

(g) A statement that a resident may not be required to perform services for the home except as provided for in the admission agreement or a subsequent written agreement. A resident and administrator or on-site manager may agree in writing that a resident will perform certain activities or services in the home if the resident volunteers or is compensated at or above prevailing rates in the community; and

(h) A copy of the house rules, which must be in writing and also posted in the facility.

House rules must be consistent with residents' rights.

House rules shall include, but not limited to, policies regarding the use of tobacco and alcohol, the times and frequency of use of the telephone, visitors, hours and volume for viewing and listening to television, radio and other audiovisual equipment, and the use of personal property.

****>>>>Based on record reviews and staff interview, the facility failed to ensure that one (1) of thirty-four (34) sampled resident files (#2) contained a current statement of fees and charges that are available on an additional fee basis. This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of the file of resident #2 showed an admission agreement signed November 21, 2005. Exhibit 2 of the admission agreement showed there were no additional fees or charges. "N/A" was placed by additional charges for incontinence supplies, personal care supplies and other charges.

A review of the fees and charges for resident #2 showed the following charges for "Medical Supplies": December 14, 2005, showed a charge for $13.00; January 13, 2006, showed a charge for $144.00 and February 14, 2006, showed a charge for $12.00.

In an interview on November 22, 2006, staff B, the administrator, stated that medical supplies include Depends, wipes and gloves. The family is billed if they do not supply these items.

A2103 Residents' Rights.

SS=D

(c) Each resident shall have the right to:

1. Exercise the constitutional rights guaranteed to citizens of this state and this country including, but not limited to, the right to vote;

2. Choose activities and schedules consistent with the resident's interests, and assessments;

3. Interact with memebers of the community both inside and outside the home and to participate fully in the life of the community; and

4. Make choices about aspects of his or her life in the home that are significant to the resident;

****>>>>Based on observation, record review and staff interview, the facility failed to allow eleven (11) of thirty (30) residents sampled (14, 23, 27, 28, 29, 30, 33, 36, 39, 41) to choose schedules consistent with the residents' interests. This resulted in no actual harm with the potential for more than minimal harm. Findings include:

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A review of the facility's shower schedule for residents on November 17, 2006, showed that six residents (#14, 23, 28, 29, 39 and 41) are bathed on the 11-7 shift and ten residents (#14, 18, 23, 27, 28, 29, 30, 33, 36 and 39) are on the daily "get up" list for the 11-7 shift.

In an interview on November 20, 2006, staff G, who works the 11-7 shift, stated that she does resident showers at 11:30 p.m. She stated that some residents are still up, but if they are not up, staff get the residents up for a shower and then they can return to bed.

Staff G stated that she gets residents up at 6:00 a.m., dresses them and lets them lay back down.

In an interview on November 20, 2006, staff L stated that she gets residents up at 6:00 a.m. for showers. She stated that you have to coax some residents to get up and some get right up.

In an interview on January 31, 2007, staff B, the administrator, stated that staff only get residents up who are early risers on the 11-7 shift. If the residents are asleep, we let them stay down and get them up in time for breakfast at 8:30 a.m.

In an interview on February 1, 2007, staff L stated that there is no "get up" list now.

In an interview on February 1, 2007, staff Q stated that resident #30 does not like to get up early for a bath and residents #28 and #30 go back to bed after their bath.

In an interview on February 1, 2007, staff L stated that she gets resident #42 out of bed early even though the resident does not like to get out of bed. Resident #42 was observed asleep in her wheelchair in the living room at 6:00 a.m. Staff L stated that resident #33 will go back to sleep after she is dressed.

In an interview on February 1, 2007, staff G stated that resident #13 does not want to get up and fights about everything. Residents #23 and #47 go back to bed after being dressed.

A2108 Residents' Rights.
SS=J

(h) Each resident shall have the rights to be free from mental, verbal, sexual and physical abuse, neglect and exploitation.

Each resident has the right to be free from actual or threatened physical or chemical restraints and the right to be free of isolation, corporal, or unusual punishment including interference with the daily functions of living, such as eating or sleeping;
****>>>>Based on record reviews and interviews, the facility failed to ensure seventeen (17) of thirty-six (36) sampled residents (5, 6, 8, 11, 12, 14, 17, 18, 20, 21, 24, 25, 26, 32, 34, 42, 48) are free from neglect and physical restraints when services were not provided to avoid physical harm to individual residents. This resulted in an imminent and serious threat to resident health and safety. Findings include:

The Resident Care Record for resident #5 in March, April and May 2006, stated, "Please do not leave unattended", fall risk.

A review of the incident reports and the progress notes of resident #5 on November 26, 2006, showed the following incidents for 2006: February 22, found on floor with a cut and swelling to the forehead; March 4, found on floor with a bruise on the head; April 12, found on floor with a bruise to the forehead; June 6, found on floor with a fractured hip, surgery June 6 and returned to facility on June 9; June 13, seen in the emergency room for aspiration pneumonia.

In a confidential interview on November 22, 2006, CC stated that resident #5 was active up until the resident broke a hip, then became bed bound.

On February 8, 2007, a review of the death certificate of resident #5, dated June 16, 2006, showed the immediate cause of death as "sequelae of hip fracture".

The Resident Care Record dated November 2005 for resident #6 stated, "monitor closely will walk outside".

A review of the home health records for resident #6 on February 8, 2007, showed a physician's order dated May 15, 2006, for home health to evaluate and treat a skin tear and abrasion on the left leg. The home health records also had a physician's order dated June 5, 2006, to evaluate and treat multiple skin tears on the resident's left extremity. There was no documentation of these injuries in the facility's progress notes or incident reports.

A review of an incident report on November 26, 2006, showed that on July 3, 2006 at 9:30 a.m., resident #6 was found outside on the ground with the wheelchair tipped over.

A review of an e-mail on November 26, 2006, showed that on July 3, 2006, Staff B, the administrator, stated that resident #6 had a "golf ball" size swelling to right forehead along with a cut. The resident also had a cut to the bridge of nose and a cut and bruise to the back of the right hand. 911 was called and the resident began vomiting during the assessment by EMS. The resident was treated at the emergency room and returned to the facility.

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A review of progress notes on November 26, 2006, showed that on July 3, 2006 at 6:00 p.m., resident #6 was sent to the emergency room with seizures and returned to the facility. On July 6, 2006, resident #6 was admitted to the hospital after the resident collapsed. The resident had a cardiac arrest at the hospital and was later transferred to a hospice facility.

A review of the death certificate on February 7, 2007, showed that resident #6 died on July 19, 2006.

A review of 2006 incident reports on November 29, 2006, showed the following incidents for resident #8: February 19, resident found on the floor at 2:30 a.m. with a skin tear to the ear; July 17, resident found on the floor with injuries to the head, resident sent to the emergency room for sutures to the frontal forehead and staples to the back of the head; August 14, resident found on the floor; August 26, resident transferred to the emergency room because he refused to ambulate. Resident was admitted with a fractured femur.

An incident report and progress notes dated March 11, 2006, were reviewed on November 29, 2006, and showed that resident fell in the kitchen which required an emergency room visit. Discharge instructions from the hospital dated March 12, 2006, stated resident has an unsteady gait and is a fall risk and needs maximum assistance with walking.

The facility Resident Care Record dated July 2006 stated resident #8 "does wander".

On December 22, 2006, Hospice notes were reviewed and stated on June 28, 2006, that resident #8 has a history of falls and Hospice notes dated July 5, 2006, stated that the resident's eyes were black and blue from a fall.

A fall risk assessment dated July 7, 2006, stated resident #8 was at high risk for falls.

Hospital records reviewed on January 11, 2007, showed that resident #8 did not regain consciousness after hip surgery and expired on September 3, 2006.

A review of the 2006 incident reports of resident #12 on November 26, 2006, showed the following incidents: September 5, resident found on floor without injuries; October 17, 2006, resident found on floor with injury to back of head requiring sutures.

A review of the facility risk assessment for falls dated October 21, 2005, was reviewed on November 26, 2006, and stated resident #12 is at high risk for falls.

A review of incident reports for resident #17 on November 26, 2006, showed the following: October 18, staff found resident #17 with a deformed left wrist; November 6, found on floor with a bruise on the cheek; November 7, resident hard to arouse, sent to emergency room.

A review of hospital records on December 27, 2006, stated that on November 7, 2006, resident #17 had an abrasion on the right side of the forehead, nose and left brow and had a hematoma on the right temple and left forehead. The hospital records dated November 7, 2006, showed a large subdural hematoma with a poor prognosis. The resident was discharged from the hospital to a hospice facility.

In a telephone interview on February 9, 2007, hospice staff stated that resident #17 died on November 13, 2006.

A review of the progress notes for resident #20 on November 22, 2006, showed on August 24, 2006, the staff noticed that the resident was unable to bear weight on the right leg. The resident was sent to the hospital and returned on August 25, 2006 at 3:00 p.m. On August 29, 2006 at 9:30 a.m., the resident was unable to bear weight and right leg was swollen. The resident was transferred to the hospital with a fractured femur and dislocated hip.

A review of an incident report on January 18, 2007, showed that on November 25, 2006, resident #20 had bruising of the left knee.

On November 26, 2006, staff B, the administrator, documented that bruising still visible, resident has pain in the knee which the daughter is aware of and has made a doctor appointment for Monday. On November 27, 2006, staff B, the administrator, documented that resident #20 was seen by physician and has a strain of the knee.

A review of incident reports for resident #21 on November 21, 2006, showed on August 21, 2006, resident fell and sustained a fractured clavicle and joint injury. On July 18, 2006, resident #21 was found outside on the grass.

A review of the fall risk assessment on November 21, 2006, showed that on August 26, 2006, resident #21 was a high risk for falls.

A review of an incident report on November 21, 2006, showed that on August 26, 2006, resident #21 fell and sustained a fractured hip.

A review of incident reports and progress notes for resident #24 on November 21, 2006, showed the following incidents in 2006: May 5, resident found on the floor with pain in the left groin area; June 16, resident exhibiting agitated behavior, swinging her hands and kicking items over, bruise was noted to the residents's little finger; July 19, staff heard resident yelling and found resident on the floor, resident had a skin tear to the upper arm; July 27, resident found on the floor with skin tear and swelling to the arms; August 23, resident fell while attempting to sit in a wheelchair and sustained red areas to both shins; August 28, resident trying to get out of the building; October 6, resident very agitated, skin tears to left forearm; October 9, resident found on the floor holding hands with another resident; October 13,

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resident tried to bite a staff member and bit a chair, breaking the skin of lip; October 23, resident #24 had a hematoma and swelling on the right forearm; October 24, resident very agitated and yelling, the hematoma was bleeding into tissue, resident sent to the emergency room and diagnosed with a wrist sprain; November 4, resident found on the floor with a bruise to the right buttock; November 19, resident #24 fell and sustained a fractured femur.

In an interview on November 20, 2006, staff G stated that resident #24 falls a lot.

A review of the facility fall risk screening on November 21, 2006 for resident #24 was dated October 8, 2006 and stated resident is a high risk for falls.

A review of progress notes on November 29, 2006, showed that on February 10, 2006, there was dried blood and bruising noted to resident #25's nose and lips.

A review of an incident report on November 29, 2006, showed that on February 24, 2006, that resident #25 was found on the floor at 3:45 a.m. with swelling to the left side of head and a skin tear to the hand. Resident #25 was sent to the hospital.

Hospital records dated February 25, 2006, were reviewed on December 27, 2006, and showed bruising of the left eye area, a skin breakdown on the sacrum, several small skin tears and a large area of bruising to the left wrist. Resident # 25 was diagnosed with a blood infection, a subdural hemorrhage and a fall from the bed and died at the hospital on February 25, 2006.

A review of the progress notes on November 29, 2006, showed that on October 10, 2005, resident #32 fell at 8:10 p.m. and was sent to the emergency room. Resident #32 returned from the emergency room on October 11, 2005 with a diagnosis of right arm pain.

A review of progress notes on November 29, 2006, showed that on October 12, 2005, resident #32 was found on floor with a knot and bruising on the front right side of head. On October 28, 2005, resident was found on the floor and was sent to the emergency room with a fractured left hip. Resident #32 was transferred to a rehabilitation center.

A review of a letter from a family member on November 29, 2006, stated that resident #32 died at the rehabilitation center on January 12, 2006.

A review of the Resident Care Record on November 29, 2006, showed that in October 2005, resident #32 needs assist with transfers.

A review of the history and physical for resident #32 on November 29, 2006, showed that on October 12, 2005, resident #32 is at high risk for falls.

A review of progress notes for resident #42 on January 18, 2007, showed that on December 10, 2006, the resident was found on left side on the floor of the resident's bedroom. Resident #42 had an abrasion above right eye, a skin tear on the right forearm, a scratch on right knee and was treated in the emergency room. On December 14, 2006, resident #42 was found on the floor. On December 29, 2006, resident #42's left ankle had a red swollen area and the resident refused to wear a shoe. The facility notified the resident's family that the resident needed to be seen by a physician. The family stated that they would see the resident that day or the next.

On January 3, 2007, resident #42's tremors were getting worse. A message was left for the resident's physician. There was no documentation that the physician returned the call or that any further action taken. On January 4, 2007, resident #42's right hand was swollen. A message was left with the physician's nurse. There was no documentation that the physician or nurse returned the call or that any further action taken. On January 7, 2007, resident #42 was admitted to the hospital with infection and medication toxicity. Resident returned to the facility on January 17, 2007.

A review of an incident report and progress notes on February 1, 2007, showed that on December 9, 2006 at 5:00 p.m., resident #48 stated that she fell in the resident's room and complained of pain in the resident's head and neck. Resident #48 went to the emergency room and was diagnosed with a contusion. On December 10, 2006 at 7:40 p.m., the resident was noted to have a bruise behind each ear.

In an interview November 17, 2006, staff B, the administrator, stated that the facility's fall prevention program is to complete a fall assessment and if the resident is at high risk for falls, a sticker is placed on the door of the resident's room to alert staff. Staff are to check these residents more often. The staff daily assignment sheets are to identify these residents that are at high risk for falls.

During a tour of the facility on November 17, 2006, eleven (11) of twenty-seven (27) resident doors (#11, 12, 14, 15, 20, 23, 28, 33, 39, 40 and 48) had a sticker on them. A review of the staff daily assignment sheets showed only two residents (#20, 24) that were identified as a fall risk.

In an interview on January 18, 2007, staff B, the administrator, stated that the stickers had been removed from the resident's doors. The administrator was unable to provide a policy or procedure on the facility's fall prevention program.

In an interview on November 20, 2006, staff D stated that residents are checked and changed every two hours, and heavy wetters are checked every thirty minutes.

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In an interview on November 20, 2006, staff F stated that stickers are on the doors to let us know which residents are at high risk. We try to check on them more often.

In an interview on November 20, 2006, staff G stated that she checks on all residents every two hours and checks on residents #20 and 33 every hour.

In an interview on November 20, 2006, staff L stated that doors are marked for falls and rounds are made every two hours.

In an interview on November 22, 2006, staff K, the activity director, stated that she did not know about the fall program, that the fall program training was for caregivers, not the activity
director. She was aware of the stickers on resident doors.

In an interview on November 29, 2006, staff B, the administrator, stated that there is no written policy or procedure for the fall program.

In an interview on January 31, 2007, staff B, the administrator, stated that she had not had time to look for the policy on fall prevention, but they feel that the fall prevention program is "ok", so no changes have been made.

A review of incident reports on November 26, 2006 and January 18, 2007, showed that the following residents were "found outside" without supervision:
resident #6 on December 7, 2005, June 28 and July 3, 2006, (requiring two emergency room visits);
resident #11 on August 20, 2006;
resident #12 on April 30, May 8 and July 14, 2006;
resident #14 on March 22, 2006 and January 19, 2007.
resident #18 on June 26, 2006;
resident #21 on July 18, 2006;
resident #24 on September 27, 2006 and
resident #34 on April 4, 2006.

A review of the May, June and July 2006 Resident Care Record for resident #6 on November 17, 2006, showed documentation under Special Needs to "monitor closely will walk outside".

In a confidential interview on December 5, 2006, AA stated that residents #6, 11, 12 and 14 could push the door open to go outside, but could not open the door to get back into the building.

In an interview on November 29, 2006, staff A, the regional director of operations, stated that resident falls were expected and unavoidable related to dementia.

In an interview on January 31, 2007, staff B, the administrator, stated that there were no locks or alarms on the outside exit doors during the day. The outside exit doors are locked from 4:30 p.m. to 7:00 a.m. The building was designed so that residents can go outside to get fresh air.

The facility documentation reviewed on November 17, 2006, showed that restraints were used on the following two residents:

The physician's report for resident #5 dated February 16, 2006, stated that resident #5 requires physical restraints (siderails up x four). Incident reports dated February 22, March 4 and April 12, 2006, stated that to prevent recurrence of falls, staff are to place resident next to a table.

Facility progress notes dated April 15, 2006, documented resident #5 attempts to get up constantly, pushed next to table while in wheelchair.

The Resident Care Record dated March 2006 said not to leave resident unattended and to push the wheelchair to table since resident is a fall risk.

A review of the incident report dated April 24, 2006, for resident #26 stated when resident is in the wheelchair, to place it next to the wall or chair to prevent falls. The incident report dated May 10, 2006, stated to place resident #26 in a reclining position to prevent falls.

Hospice documentation dated May 30, 2006 and June 20, 2006, stated that a large chair was placed in front of resident# 26's wheelchair to prevent resident from falling out of the chair.

In a confidential interview on December 5, 2006, AA stated that resident #26 was reclined in the wheelchair to prevent falls by preventing the resident from rising.

In an interview on November 22, 2006, staff H stated that resident #26 was reclined in the wheelchair to prevent the resident from rising due to falls.

In an interview on November 17, 2006, staff B, the administrator, stated that resident #26 was reclined in the wheelchair to help him relax

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and to make it more difficult for him to get up.

Cross refer to Rule 290-5-35-.13(1) Staffing A1601.

A2204 Medications.
SS=D

(4) Storage of Medications:

(a) Medications shall be stored under lock and key at all times whether kept by a resident or kept by the home for the resident, except when required to be kept by a resident on his or her person due to need for frequent or emergency use, as determined by the resident's physician, or when closely attended by a staff member; and

(b) Medication kept by a resident may be stored in the resident's bedroom, in a locked cabinet or other locked storage container. Single occupancy bedrooms which are kept locked at all times are acceptable.

Duplicate keys shall be available to the resident and the administrator, on-site manager or designated staff.

****>>>> Based on observation and interview, the facility failed to store medications under lock and key as required. This resulted in no actual harm with the potential for more than minimal harm. Findings include:

During a tour on the Bungalow hall on January 31, 2007 at 9:25 a.m., the storage box for insulin was not locked.

In an interview on January 31, 2007 at 9:30 a.m., Staff N stated that the home health nurse left the box unlocked.

A2311 Nutrition.
SS=D

(11) A home shall arrange for special diets as prescribed.
****>>>Based on observation, record review and staff interview, the home failed to provide special diets for three (3) of three (3) residents requiring special diets (#42, 33, 44) . This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of the file of resident #42 on January 18, 2007, showed a diet order for Special Diet 1.

A review of the file of resident #33 on January 18, 2007 showed a Special Diet 2.

A review of the file of resident #44 on February 1, 2007 showed an order for Special Diet 3.

Breakfast was observed at 8:30 a.m., on January 31, 2007. All residents were served bacon, eggs, oatmeal, french toast and sweetened orange juice.

In an interview on January 31, 2007, staff N stated that the above residents were served the same foods as other residents. Special foods were not available.

Breakfast was observed at 8:05 a.m., on February 1, 2007. All residents were served sausage, eggs, grits and an english muffin.

In an interview on February 1, 2007, staff F stated that the above residents were served the same foods as other residents.

There were no menus for special diets.

A2401 Procedures for Change in Resident Condition.
SS=D

(1) In case of an accident or sudden adverse change in a resident's condition or adjustment, a home shall immediately obtain needed care and notify the representative, or legal surrogate, if any.

A record of such incidents shall be maintained in the resident's files.
****>>>>Based on record review and staff interview, the facility failed to obtain needed medical care when a resident had a change in condition for three (3) residents of three (3) residents (#3,6,14). This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of the facility's progress notes on November 20, 2006 showed that on April 1, 2006 at 3:00 p.m., resident #3 was noted to have edema in her legs. On April 2, 2006 at 12:30 p.m., the resident #3 continued to have edema in legs. On April 3, 2006 at 2:45 p.m., documentation showed that the resident's family member and physician were notified of the edema in resident #3's legs. Resident #3 was

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seen by the physician on April 6, 2006 at 10:00 a.m.

A review of the home health records on February 8, 2007, showed a physician's order dated May 15, 2006, for home health to evaluate and treat a skin tear and abrasion on the left leg of resident #6. The home health records also had a physician's order dated June 5, 2006, to evaluate and treat multiple skin tears on the resident's left extremity. There was no documentation of these injuries in the facility's progress notes or incident reports.

A review of facility progress notes on February 1, 2007, showed that resident #14 was found lying on the ground outside at 3:40 p.m. on January 19, 2007. The resident was noted to be off balance when walking. Staff P put the resident on bedrest and notified the family. The family responded at 4:00 p.m. and told staff not to send the resident out by 911, the family would assess the resident. There is no documentation of that the physician was notified or that any further action was taken.

A2402 Procedures for Change in Resident Condition.
SS=J

(2) Immediate investigation of the cause of an accident or injury involving a resident shall be initiated by the administrator or on-site manager of the home and

A report made to the representative or legal surrogate, if any, with a copy of the report maintained in the resident's file and in a central file.

****>>>>Based on record reviews and staff interviews, the facility failed to initiate an investigation into the causes of accidents or injuries documented for residents in 114 of 139 incidents reviewed. This resulted in no actual harm with the potential for more than minimal harm. Findings include:

A review of the facility's incident reports on November 21, 2006, for January through November 2006, showed the following:

January - one of five incidents did not have documentation of an investigation (resident #9)
February - six of ten incidents did not have documentation of an investigation (residents #7, 8, 10, 25)
March - nine of thirteen incidents did not have documentation of an investigation (residents #1, 4, 11, 13, 14, 21, 26 35, 36)
April - eight of ten incidents did not have documentation of an investigation (residents #4, 7, 12, 26, 28, 37)
May - five of eight incidents did not have documentation of an investigation (residents #7, 19, 26, 28, 33)
June - fifteen of eighteen incidents did not have documentation of an investigation (residents #5, 6, 7, 14, 15, 24, 26, 37, 38)
July - twenty-one of twenty-one incidents did not have documentation of an investigation (residents #6, 7, 8, 10, 11, 12, 14, 15, 21, 22, 23, 24, 26, 28)
August - eleven of thirteen incidents did not have documentation of an investigation (residents #8, 10, 11, 13, 14, 20, 21, 24, 28, 33)
September - seven of seven incidents did not have documentation of an investigation (residents #12, 24, 27, 30, 33, 39)
October - nine of ten incidents did not have documentation of an investigation (residents #24, 11, 12, 17, 19, 40)
November - ten of eleven incidents did not have documentation of an investigation (residents #11, 14, 15, 19, 20, 24, 33)

In a confidential interview on December 5, 2006, AA stated that follow-ups were done on accidents/incidents, but an investigation including measures to prevent recurrences was not done.

In an interview on January 31, 2007, staff B, the administrator, stated that an investigation is now being completed, depending on the incident.

A review of the facility's incident reports on January 18, 2007, for December 2006, showed four of five incidents did not have documentation of an investigation (residents #11, 14, 43, 48).

A review of the facility's incident reports on February 1, 2007, for January 2007, showed eight of eight incidents did not have documentation of an investigation (residents #11, 14, 20, 33,40, 43, 46).